

DEPARTMENT OF HEALTH FOR SCOTLAND
SCOTTISH HEALTH SERVICES COUNCIL

Mental Health Services of Local Health Authorities

*Report by the Standing Advisory Committee
on Local Authority Services*



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SUMMARY OF RECOMMENDATIONS

COMMUNITY CARE

1. The object of every local authority must be to expand their mental health services to the point at which no person need be resident in hospital unless he will benefit from or requires hospital care. (Paragraph 6).

NUMBERS

2. Local health authorities should undertake and keep up to date a survey of the numbers of mentally disordered persons within their areas likely to require the various services referred to in the Report, but this must not delay the provision of services for which there is an evident need. (Paragraph 10).

CO-OPERATION

3. Co-operation between the various bodies providing services for persons suffering from mental disorder is essential. Joint committees representing local authorities, hospitals, general practitioners and voluntary mental health associations should be established to keep under review existing mental health services and plans for future development. (Paragraph 80).

GENERAL

4. Local health authorities should consider measures to promote mental health education and to enlist public support for the community care of the mentally disordered. (Paragraph 81).

5. In providing services jointly, local health authorities should aim at simplicity of administration; and the local authority associations should be asked to advise on model administrative schemes and suitable financial arrangements for joint services. (Majority recommendation only—paragraph 83).

6. Local health authorities should see that the officer in charge of their mental health services is suitably qualified. (Paragraph 84).

7. Each health committee of a local authority should appoint a mental health sub-committee. (Paragraph 85).

SERVICES FOR MENTAL DEFECTIVES

Guardianship and Informal Supervision

8. Local health authorities should aim at providing the same service in the way of advice, visits, etc., to all grades of mental defectives in the community and to all those looking after them who need it and desire it, whether or not the mental defectives are under formal guardianship. Supervision should continue to take the form of regular informal visits by medical and other officers of the local health authority. (Paragraph 13).

9. As an immediate first step towards creating a service of informal supervision, local health authorities should extend to mental defectives known to them to be awaiting admission to hospital at least the same visiting service as they at present give to mental defectives under guardianship, where they do not already do this. (Paragraph 15).

ASCERTAINMENT

Pre-school Children

10. In all areas local health authorities should discuss with general practitioners the best way of ensuring early ascertainment of mental defect, and should encourage them to consult the local authority before the child reaches the age of 3 about any case where there may be mental handicap. Local health authorities should also arrange for health visitors to see all children between the ages of 2 and 3, where this is not already done. (Paragraph 17).

11. Each local health authority should see that specialist diagnostic services are available when required. (Paragraph 18).

School Age Children

12. Local health authorities should encourage education authorities to inform them of any children who, while capable of receiving education within the school system, might yet benefit from informal supervision at home which the education authority are unable to provide. (Paragraph 20).

13. Local health authorities should encourage education authorities to interpret their duty under section 57 of the Education (Scotland) Act, 1946, as broadly as possible in order to ensure that no child will be lost sight of on leaving school if there is any possibility that he may benefit from local health authority services. (Paragraph 21).

Assessment of Need in Adults

14. In order to assess the number of mental defectives already adult in the community, local health authorities should co-operate with bodies such as the National Assistance Board, employment exchanges, voluntary societies, the school health service, the hospital service and general practitioners to collect information about adult mental defectives who may be in need of help. (Paragraph 22).

TRAINING AND OCCUPATION

15. Local health authorities should provide special transport where appropriate for children and adults attending work centres or occupation centres, and, where special transport is not provided, should refund travelling expenses in appropriate cases. (Paragraph 25).

Pre-school Children

16. Local health authorities, individually or in combination, should establish special day nurseries for pre-school children with severe mental handicap. Where such children cannot attend day nurseries, local health authorities should

ensure that the parents know of available services and have access to them, and also, where possible, that the parents are instructed in the care and training of the child at home. (Paragraph 27).

School Age Children

17. Where it is at all practicable, local health authorities, individually or in combination, should establish junior occupation centres for children of school age unsuitable for education or training in a special school, or should provide training and occupation for one or two days a week wherever three or four children can be collected together. (Paragraphs 28 to 29).

18. Local health authorities in areas of scattered population, where it is not practicable to provide training and occupation even for small groups of children, should make individual arrangements for mentally defective children in their area. (Paragraphs 32 to 33).

19. Wherever appropriate, local health authorities should arrange for mentally defective children (or adults) to be admitted to hospital for a short period of intensive habit training and other treatment to make them as self-reliant as possible at home. (Paragraphs 32 and 39).

20. Officers of the education authority should consult officers of the local health authority before the formal decision is taken that a child is unsuitable for education or training in a special school. (Paragraph 34).

Mental Defectives over 16

21. Local health authority officers responsible for the supervision of adult mental defectives should at all times keep in very close touch with the Youth Employment Service, the disablement resettlement services, employment exchanges, voluntary bodies and officers of the local authority's welfare department concerned with sheltered employment for disabled persons under the National Assistance Act. (Paragraph 35).

22. Local health authorities, individually or in combination, should take immediate steps to set up senior occupation centres and work centres, where they have none at present, and to review and if necessary increase their present provision, where they have already established such centres. Where instruction even in small groups from travelling instructors is not possible, local health authorities should make individual arrangements for mental defectives. Local health authorities in combination should consider the establishment of a residential rural training centre. (Paragraphs 36 to 39).

RESIDENTIAL ACCOMMODATION

Short-term Homes

23. All local health authorities should see that short-stay residential accommodation is available for mental defectives, both adults and children, from their area, with the object of relieving those looking after them during periods of domestic stress or for holidays. (Paragraph 40).

Longer term Hostels for School Age Children

24. Local health authorities should consider the establishment of a residential junior occupation centre as a long term objective. (Paragraph 42).

25. Local health authorities should consult with education authorities to see whether a need exists in their area for hostels for mentally handicapped children capable of education in a day special school. (Paragraph 43).

Residential Accommodation for Adults

26. With regard to the provision of hostel accommodation for adults, every local health authority should consider the needs of the different groups of mental defectives in their own area and make provision initially for whichever seems to be the most pressing. Various groups who may be in need of accommodation are described. While local health authorities should first concentrate on the needs of those now in the community or those who can enter into community life with a fair measure of success on leaving hospital, they should also plan to relieve the hospital service in due course of the care of some homeless and unemployable mental defectives who are not in need of hospital care, regarded here as including constant and close supervision. (Paragraphs 44 to 48).

OTHER SERVICES

Mental Defectives leaving Hospital

27. To ensure adequate follow-up for all mental defectives discharged from hospital, local health authorities should ensure that they keep in close touch with the hospital. (Paragraph 49).

Maintenance Payments; Clothing and Bedding

28. Local health authorities responsible for the supervision of mental defectives should keep in close touch with the officers of the National Assistance Board dealing with maintenance payments in respect of the defectives. (Paragraph 50).

"Sitter-in" Service

29. Local health authorities should consider whether there is a place in their area for a "sitter-in" service designed to relieve parents of the care of home-bound mental defectives for short periods. (Paragraph 51).

Social Clubs

30. Local health authorities should initiate and support, and where appropriate co-operate with hospital authorities in the provision of, clubs for mental defectives and clubs for their parents and guardians, which would have the important function of providing practical advice. (Paragraph 52).

Voluntary Help

31. Local health authorities should give adequate financial and other support to any voluntary organisation providing mental health services in the local authority's place in their area. (Paragraph 53).

SERVICES FOR THE MENTALLY ILL

Aftercare for those leaving Hospital

32. Local health authorities should co-operate with hospitals and general practitioners in the aftercare of patients leaving hospital and should ensure that

general practitioners and hospital doctors are fully aware of the aftercare services which they can offer. To provide continuity between the patient's hospital treatment and his life in the community, social workers, whether employed by the local authority, the hospital, or jointly by both, should make contact with the patient and with his family while he is still in hospital, and, after the patient's discharge, should provide any necessary support by means of home visits. (Paragraphs 57 to 58).

Patients under Guardianship

33. The supervision of mentally ill patients under guardianship should take the form of regular, informal visits from local authority medical officers and social workers. (Paragraph 59).

Prevention of Mental Illness

34. Local health authorities should keep in mind the importance of adequate services for old people in the prevention of mental ill-health. (Paragraph 60).

35. Local health authorities should encourage general practitioners to ask for the assistance of local authority social workers, acting if necessary under specialist psychiatric guidance, where patients need regular support to prevent mental breakdown. (Paragraph 61).

Social Clubs

36. Local health authorities should initiate, encourage, or co-operate with hospitals in the provision of social clubs for persons suffering or recovering from mental illness. (Paragraph 62).

Residential Accommodation

37. Local health authorities should consider whether there is a need in their area for hostels for employable patients leaving hospital. While concentrating first on the needs of these patients, local health authorities should also consider whether they should provide further accommodation, combined with work centres, for unemployable patients at present in hospital who no longer need hospital care. (Paragraphs 63 to 65).

Lodgings

38. Local health authorities should assist in finding suitable lodgings of approved standard for patients leaving mental hospitals. (Paragraph 66).

Homes for Old People

39. Local health authorities or welfare authorities should provide homes for aged mentally disturbed persons. (Paragraph 67).

Short-term Residential Accommodation

40. Local health authorities should consider possible arrangements to provide short-term accommodation for mentally ill patients, to relieve those looking after them in periods of domestic stress or for holidays. (Paragraph 68).

Training and Occupation: Employment

41. Local health authorities should assist in finding patients jobs on discharge from hospital. (Paragraph 70).

42. Local health authorities should provide work centres or occupation centres for mentally ill patients whose illness has left them unfit for ordinary employment, or should arrange with hospitals for the daily attendance of patients from the community at work centres or occupation centres provided within the hospital. Local health authorities should provide special transport or refund travelling expenses where appropriate for persons attending work centres (or day centres for the elderly). (Paragraph 72).

Mental Health Services of Local Health Authorities

INTRODUCTION

1. In May, 1960, we were asked by the Secretary of State for Scotland
"Having regard to the new mental health legislation in prospect, to consider and advise on the future development of the mental health services of local health authorities, with particular reference to the content of arrangements to be made by these authorities under section 27 of the National Health Service (Scotland) Act, 1947."

2. We have held nine meetings in the course of which we have considered this remit. We have not taken evidence: the time available has not allowed any extensive exploration of the views of those persons and bodies at present working in the field of local authority mental health services, since we were asked to treat our Report as a matter of urgency. We have however had the benefit of the attendance, each at one meeting of the Committee, of Dr. D. Ross, Physician Superintendent, Stratheden Hospital, Fife; Dr. P. Sykes, Physician Superintendent, Ladysbridge Hospital, Banff; and Mr. T. Tinto, Principal Welfare Services Officer, Glasgow Corporation. We should like to express our gratitude to them for their assistance.

STATUTORY BACKGROUND

3. The Committee's remit, quoted in paragraph 1, refers to section 27 of the National Health Service (Scotland) Act, 1947. This section forms the basis of local health authorities' powers to provide care and aftercare for the mentally ill and mental defectives. It provides that

"A local health authority may with the approval of the Secretary of State, and to such extent as the Secretary of State may direct shall, make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental deficiency, or the after-care of such persons."

It will be noted that local authorities' powers under this section may be converted into duties by means of a direction of the Secretary of State. In D.H.S. Circular 75/1960, dated 20th October, 1960, the Secretary of State has directed that arrangements shall be made by every local health authority for the purpose of the prevention of mental disorder and the care and aftercare of persons who are or have been suffering from mental disorder (i.e. mental illness or mental deficiency). Local health authorities are therefore now under obligation to provide mental health services, and have been told, in the same circular, that in due course they will be required to submit to the Secretary of State their proposals for the development of those services. Part of our function is to advise on the content of those proposals.

4. At the time when we were given our remit, the Mental Health (Scotland) Bill was before Parliament. This has now become the Mental Health (Scotland) Act, 1960, although as yet none of its provisions is in operation, except those relating to the admission of patients to mental hospitals without formality. Part II of the new Act deals with local authority services. The sections which are

of particular concern to local health authorities are sections 7 and 12. Section 7 recites some particular services which may form part of local health authorities' arrangements under section 27 of the 1947 Act for the care and aftercare of persons who are or have been suffering from mental disorder. This list of particular functions is not, however, necessarily exhaustive, and in no way limits local authorities' general powers under section 27. Section 12 of the new Act imposes on local health authorities a duty to provide training and occupation for children under 16 who have been excluded from the school system because of disability of mind, and for adult mental defectives. This section repeals and replaces, with minor modifications only, the similar duty imposed on local health authorities by section 51 of the 1947 Act.

5. We shall refer in more detail to particular items listed in section 7 of the new Act in later parts of our Report. We should mention here, however, two of the items which relate to later parts of the Act. Section 7(1)(c) refers to local health authorities' functions in respect of persons under guardianship. Local health authorities have of course long had duties and powers in relation to mental defectives placed under guardianship; the new legislation continues to make provision for admission to formal guardianship under the supervision of local health authorities, and applies these provisions to persons suffering from mental illness as well as to those suffering from mental deficiency. Section 7(1)(b) refers to "the appointment of officers to act as mental health officers under the following provisions of this Act". The mental health officer corresponds to the "authorised officer" under the present legislation and continues that officer's long-established function of setting in motion the procedure for compulsory admission to hospital or reception into guardianship, where this is necessary and the patient's relatives are unable or unwilling to take action. A mental health officer may also be an officer of the local authority's health or welfare department charged with other duties in the sphere of mental health, such as the supervision of mental defectives under guardianship; his designation as such may vary from authority to authority, but his statutory duties as a mental health officer within the meaning of the new Act are confined to the compulsory procedures.

COMMUNITY CARE

6. One of the general principles which the Royal Commission on the law relating to mental illness and mental deficiency in England and Wales* laid down for the future was that there should be increased emphasis on care in the community, rather than institutional care, for those suffering from mental disorder. This principle was endorsed by the Committee of the Scottish Health Services Council (the Dunlop Committee) which considered the application to Scotland of the major recommendations of the Royal Commission.† In our view, the object of every local authority must be to expand their mental health services to the point at which no person need be resident in hospital who will not benefit from or does not require hospital care: we say more, particularly in paragraphs 42, 46, 47, and 65, about what we consider to be the proper dividing line between hospital care and community care. This will involve both the provision of services to reduce the need for hospital admission for those now in the community, and the provision of adequate aftercare and other services to enable

* Cmnd. 169. H.M.S.O. Price 10s. 6d. (by post 11s. 4d.)

† Mental Health Legislation, 1959. H.M.S.O. Price 1s. (by post 1s. 2d.), Second Report by a Committee appointed by the Scottish Health Services Council.

hospital in-patients to return to the community after as short a period of hospital treatment as possible.

INFORMALITY

7. It is a further principle of the new legislation, clearly stated in the case of admission to hospital (section 23(3)), that treatment and other services must be available without formality to anyone who needs them and is willing, or at any rate not unwilling, to receive them. This principle applies in the sphere of local health authority services as well as in the hospital service.

CO-OPERATION

8. A third important principle which must be remembered in considering local health authority services is that the health department of the local authority cannot work in isolation. At this stage we will merely say that we emphasise at many points in the course of our Report the vital importance of co-operation between the various bodies providing services for persons suffering from mental disorder, and that we deal with the general issue more fully in paragraphs 73 to 80 of our conclusion.

SEPARATE PROBLEMS OF MENTAL ILLNESS AND MENTAL DEFICIENCY

9. We thought it appropriate to consider separately services for mental defectives and services for the mentally ill. The Mental Health (Scotland) Act, 1960, assimilates the legislation relating to mental defectives to that relating to the mentally ill, and in general refers to both categories of patients as "mentally disordered". The Act recognizes, however, by making separate reference in some instances to mental defectives alone, that in the sphere of local authority services the two categories may require somewhat different provision. Generally speaking, the part of local health authorities in caring for mental defectives is by experience more clearly defined than their part in caring for the mentally ill: while their present services for mental defectives in some cases are in an advanced stage of development, provision for mentally ill patients is only just beginning. This is reflected in the fact that we have ourselves devoted more of our meetings and a larger section of our Report to local authority services for mental defectives. We hope, however, that the fact that they are more familiar with their part in the community care of mental defectives will not lead local health authorities to neglect their duties towards the mentally ill.

NUMBERS

10. The problem of the numbers for whom local health authorities may expect to have to cater presents considerable difficulty. We have not attempted to give any precise estimate of, for example, the numbers of mental defectives in the community who may require supervision from local health authorities or formal guardianship, or for whom training and occupation should be provided, or of the numbers of mentally ill patients leaving hospital who may need continued support. The incidence of mental deficiency in the community, in particular, is a matter on which it is difficult to reach any final conclusions: the situation has not changed since the Report on Mental Deficiency in Scotland*

* Mental Deficiency in Scotland, 1937. A Report by a Sub-committee of the Standing Medical Advisory Committee. H.M.S.O. Price 1s. (by post 1s. 2d.).

stated that "such basic questions as the number of mental defectives and how many require one or other form of supervision or institutional care cannot at present be answered accurately". Where we feel that this might be helpful, however, we have quoted present figures, for example, for mental defectives under guardianship, and have attempted to indicate whether these may be expected to increase or decrease. Apart from this, it must be one of the first tasks of every local health authority to form an estimate of the size of the need in their particular area. As we shall point out particularly in paragraph 22, this will involve co-operation with hospitals, general practitioners, education authorities, welfare authorities, voluntary bodies and bodies concerned with employment and rehabilitation. We recommend that local health authorities should as a matter of urgency set on foot a survey of the numbers of mentally disordered persons within their areas, and make an estimate of the numbers likely to require the various services referred to in this Report. We would stress however that the provision of services for which there is an evident need should not be held up pending completion of the survey. Once their estimate has been formed, local health authorities should of course see that it is kept up to date.

SERVICES FOR MENTAL DEFECTIVES

11. Local health authorities' services in respect of mental defectives may be divided broadly into formal guardianship (section 7(1)(c) of the 1960 Act) and the related function of informal supervision (section 7(1)(f)); the provision of training and occupation (section 12); the provision of residential accommodation (section 7(1)(a)); and other miscellaneous services (section 7(1)(d)). The prerequisite of the provision of any services is the process of discovering those who need them - in terms of section 7(1)(c) the "ascertainment" of mental deficiency. We have set out our views under each of these broad headings below. But while separate headings are convenient, this must not give the impression that the population for whom each service is provided is separate and distinct: it is perhaps unnecessary to say, for example, that mental defectives for whom training and occupation are provided by the local health authority may also need informal supervision at home by means of regular visits, or that the fact that a child is capable of benefiting from education within the school system does not necessarily preclude a need to arrange for his reception into formal guardianship under the supervision of the local health authority.

GUARDIANSHIP AND INFORMAL SUPERVISION

12. Local health authorities already have power, under section 27 of the National Health Service (Scotland) Act, 1947, to provide informal supervision for mental defectives, but the 1960 Act, in section 7(1)(f), for the first time specifically refers to "the supervision" - by local health authorities - "of persons suffering from mental deficiency who are neither liable to detention in a hospital nor subject to guardianship". At the same time, the Act makes it plain (section 25(4)(c)) that before a patient can be received into formal guardianship, it must be "necessary in the interests of the health or safety of the patient or for the protection of other persons that the patient should be so received". That is, the doctors making the medical recommendations, and the sheriff approving the guardianship application, must be satisfied that there is no other satisfactory

way of dealing with the patient in the community. It will therefore not be possible to place a patient under formal guardianship in future if informal supervision from the local authority is sufficient to provide him with the care and treatment that he needs.

13. We consider that local health authorities should accordingly aim at providing the same service in the way of advice, visits, etc., to all mental defectives in the community and to all those looking after them who need it and desire it, whether or not the mental defectives are under guardianship. We consider that supervision should continue to take the form of regular visits by medical and other officers of the local health authority; but we wish to emphasise that such visits, whether or not the defectives are under statutory guardianship, must be kept as informal as possible. If local health authority supervision is to be effective, the visiting officer must become the friend of the patient and of those looking after him, and it is important that those looking after mental defectives should know that they can at any time ask the local authority officers for advice or help on any particular problem.

14. The number of mental defectives under guardianship in Scotland has remained fairly constant in recent years, at about 2,500. We would expect that, under the new legislation, the numbers subject to formal guardianship will decrease, particularly in the case of those at present under the guardianship of related guardians, once local health authority services are available as freely to all as to those under guardianship. It seems clear, however, that there are a large number of mental defectives living in the community and not at present under guardianship who would benefit from supervision by the local health authority of the kind at present offered to patients under guardianship, and whose parents or other guardians would be willing to receive such help. In general, therefore, we consider that local health authorities should expect to have to provide home supervision by means of regular visitation for a number of mental defectives very considerably larger than, perhaps double, the numbers of those at present under formal guardianship.

15. The process of finding out those mental defectives who should, but at present do not, receive supervision or other services forms the local health authority function of "ascertainment", with which we deal below. Local health authorities' supervisory services should grow automatically as the process of discovering those in need becomes more thorough. We hesitate to give priority where all needs are urgent, but we should mention two particular groups to whom local authorities might turn their immediate attention. With the present shortage of mental deficiency beds in hospitals, most local authorities have within their areas a number of mental defectives who clearly need hospital treatment, but for whom it is impossible to arrange immediate admission. We recommend that, as an immediate first step towards creating a service of informal supervision, local health authorities who do not already do this should extend to mental defectives known to them to be awaiting admission to hospital the same visiting service that they at present give to mental defectives under guardianship, or, indeed, a more intensive service if the defectives' condition requires it. A second group who may be in particular need of informal supervision are children leaving special schools; we say more of this in paragraph 21.

ASCERTAINMENT

16. We do not use the term "ascertainment" in the sense of a formal procedure, as it is used in section 54 of the Education (Scotland) Act, 1946, which

relates to the duty of education authorities to ascertain children suffering from disability. As we see it, the local health authority's function of ascertainment is simply one of " assessing need ". Our discussion below therefore deals with the process of discovering all those who may be in need of some help, and is not confined to those whose defect is so severe that they would be excluded from the school system or would be subject to be dealt with under the existing Mental Deficiency Acts.

Pre-school Children

17. We recognise that in most areas children suffering from mental disability become known to the health department of the local authority at an early age through the existing child welfare and health visiting services. The aim of every local health authority must be to ensure that these services are such that no child in need of treatment, training or other special help because of mental disability can escape their notice. The general practitioner has an important part to play here, and we recommend that as a first step local health authorities should discuss with general practitioners in their area the best way of ensuring that all children suffering from mental disorder are discovered at an early age. General practitioners should be asked to consult the local health authority, before the child reaches the age of 3 years, about any case in which there may be mental handicap; but we emphasise that they will be less likely to do so unless they know that the local health authority are in fact able to offer practical help in such cases. We also attach particular importance to health visitors seeing all children in the local health authority's area between the ages of 2 and 3 years, and we recommend that any local health authority who have not already arranged this should do so. Where, as a result of such a visit, there is reason to suspect mental handicap, we suggest that the Medical Officer of Health should write to the child's general practitioner, to ask if he would wish himself to arrange for the necessary investigation, or if he would like the local authority to undertake it, and whether, if the local authority carry out the investigation, the general practitioner would himself wish to communicate the results to the parents. Where it is agreed that the local authority should undertake the investigation, this could be carried out by local authority medical officers either in the home or in child welfare or other existing clinics.

18. Each local health authority should see that specialist diagnostic services are also available when required. These arrangements may take the form of calling in hospital consultants for domiciliary consultations, or of referring the child to the existing hospital service out-patient clinics, but in some cases it may be necessary for the local health authority themselves to provide premises for a special diagnostic clinic, staffed in part from the hospital service.

19. Under section 54 of the Education (Scotland) Act, 1946, parents may ask the education authority to examine a child between the age of 2 and 5, with a view to the ascertainment of mental or physical handicap. If the education authority then decide that the child, even at that age, is clearly not going to be suitable for education within the school system, they will be able to report the child formally to the local health authority without waiting until he reaches the age of 5. We should like to emphasise, however, that it is equally important that the education authority should be encouraged to inform the health authority of those children examined by them at the parents' request who, while likely to be educable within the ordinary school system, might meantime benefit from informal supervision or other assistance from the health authority.

School Age Children

20. Children of school age are excluded from the local health authority's function of ascertainment under section 7(1)(e) of the 1960 Act, because the education authority have a duty to ascertain which children of 5 years old or over in their area either require special educational treatment or are suffering from a disability of mind to such an extent that they are unsuitable for education or training in a special school (which includes an education authority occupation centre). If their decision is that the child is "untrainable", they have a duty to report the child to the local health authority under section 56 of the 1946 Act. In addition, however, we recommend that local health authorities should encourage education authorities to inform them of any children who, while capable of receiving education within the school system, might yet benefit from informal supervision at home which the education authority are unable to provide.

21. Under section 57 of the Education (Scotland) Act, 1946, education authorities have hitherto had a duty to inform the local health authority of any child who is suffering from a disability of mind of such a nature or to such an extent that he may require to be dealt with under the Mental Deficiency Acts after leaving school. This is now replaced by the much wider duty to report to the local health authority any child who is suffering from mental deficiency to such an extent that he may, on leaving school, benefit from any of the services which the local health authority have power to provide. We recommend that local health authorities should encourage education authorities to interpret their duty under this section as broadly as possible, in order to ensure that no child will be lost sight of on leaving school if there is any possibility that he may benefit from local health authority services. The particular groups of children we have in mind who should be made known to the local health authority are:

- (a) those leaving school who can obtain a job, but who may become a social problem unless they can receive friendly advice and supervision at home, or possibly special accommodation in a hostel;
- (b) those who may need help in finding or keeping a job within their capacity, or who may need a period in a work centre before they can hope to find employment; and
- (c) those who will need sheltered employment, or those who cannot hope to graduate beyond an occupation or work centre.

We say more in paragraphs 35 to 39 about the provision which we believe local health authorities should make for the training and occupation of these groups of children.

Assessment of Need in Adults

22. The assessment of the number of mental defectives already adult in the community who may be in need of services that they are not at present receiving is perhaps the most difficult part of local health authorities' function of ascertainment. Fortunately it should be only an interim difficulty since we hope that in future few mental defectives will reach adult life without becoming known to the local health authority. It has been suggested that, at any rate in industrial areas, a good deal of information is already available about adult mental defectives, but that this is scattered among a variety of sources. We therefore recommend that local health authorities should co-operate with bodies such as the

National Assistance Board, employment exchanges, voluntary societies, the school health service, the hospital service and general practitioners to collect information about adult mental defectives who may be in need of their services. We should like to emphasise here, as we do later in connection with training and occupation, that we do not intend that the local health authority should trespass on the spheres of other bodies concerned particularly with the employment of handicapped persons; the important point is to ensure that local health authorities obtain all necessary information about those mental defectives whose degree of handicap may be too severe to make them eligible for the services of these other bodies.

TRAINING AND OCCUPATION

23. Section 12 of the 1960 Act places on local health authorities a duty to provide, or secure the provision of, suitable training and occupation for

(a) children reported to them by the education authority under section 56 of the 1946 Act, as unsuitable for education or training in a special school; and

(b) persons suffering from mental deficiency who are over the age of 16.

The children under (a) above may include some children under the age of 5, since amendments made by the 1960 Act make it possible, where parents present a child voluntarily for medical examination between the ages of 2 and 5, for the education authority to report the child as unsuitable for the school system without waiting until the child reaches the age of 5. In general, however, the dividing line between the responsibilities of the education authority and the local health authority will be less clear cut in the case of pre-school children, since the step of formally reporting a child is unlikely to be taken in many cases before the child reaches the age of 5. In what we say below about pre-school children we have tried to avoid trespassing on the duty of the education authority to make ordinary nursery school provision.

24. Equally there may be some overlap between the education authority and the local health authority in the provision made for adult mental defectives. At least one education authority have used their further education powers to establish senior occupation centres for persons over 16. The duty imposed on local health authorities is not necessarily a duty to provide training and occupation themselves. They may instead see that it is provided through a voluntary organisation, to whom they may give financial assistance. Alternatively they might agree with the education authority that the education authority will use their further education powers to provide senior occupation centres. But it is clear that, if the education authority decide not to use their further education powers in this way, the duty to provide senior occupation centres rests on the local health authority: there can be no question of local health authorities evading this duty by seeking to place the responsibility on education authorities.

25. Subsection (3) of section 12 of the 1960 Act places a duty on local health authorities to "make such provision as they may think necessary for securing that transport is available for the conveyance of persons for the purpose of their training and occupation in pursuance of this section". In our view local health authorities should not only provide special transport where appropriate for children and adults attending work centres or occupation centres, but should

also, where special transport is not provided either because the numbers are too small to make this economic or because the trainees are capable of making their own way to the centre, refund travelling expenses in appropriate cases.

Pre-school Children

26. We do not recommend that local health authorities should make any special nursery provision for less severely handicapped pre-school children who are suitable for admission to an ordinary day nursery or an education authority nursery school or class, unless, exceptionally, provision of ordinary nurseries or nursery schools is lacking, and it is essential that the parents should be relieved of the care of the child for short periods.

27. We do however recommend that local health authorities should establish special day nurseries for children with severe mental handicap who could not be admitted to an ordinary nursery. The number of such children in any one area will be small, and it may therefore be necessary for neighbouring local health authorities to combine for this purpose. Separate nursery premises would not be essential: the nursery might well be contained in the same building as a local health authority junior occupation centre, or might be provided, in association with the hospital service, on hospital premises. Such nurseries might provide toilet training, training in feeding and dressing themselves, and physiotherapy for those who might benefit from it. This care and training would be of particular value in the case of children who seem likely to be mentally capable of attending an education authority junior occupation centre when they reach school age, but who seem unlikely to be socially or physically acceptable for such a centre unless they received special attention. Such nurseries would also perform the most important additional function of relieving the parents and the rest of the family of the care of the child for some part of the day. Finally, they might also serve as observation centres in cases where the day to day observation of the child by skilled nursery staff over a period of time would be of assistance in arriving at a final diagnosis of the degree or nature of the disability. Where, however, a pre-school child is unable to attend a day nursery, but requires care or aftercare services or physiotherapy or other special treatment, local health authorities in co-operation with general practitioners and the hospital and specialist services should ensure that the child's parents know of the existence of these services and have access to them. Where possible, local health authorities should also make arrangements for the instruction of the parents in any necessary care and training of the child at home.

School Age Children

28. We recognise that the number of children of school age for whose training and occupation the local health authority are responsible will be small in any one area, since they comprise only those children whose mental and other disability is so great that they are unsuitable even for an education authority junior occupation centre, in other words, children who are both "ineducable" and "untrainable" in educational terms. Nevertheless we recommend that all local health authorities should establish junior occupation centres where this is at all practicable.

29. In view of the small number of children involved in any one area, it may be necessary for local health authorities to combine to provide occupation centres, for example, a large burgh and a county council might combine to

provide a centre for children from the burgh and from the surrounding landward area. In areas of more scattered population, local health authorities might consider arranging for small groups of children, wherever three or four can be collected together, to receive care and training for one or two days a week, perhaps in a suitable village hall or even a private house, from an instructor travelling round for this purpose. In cases where care cannot be provided daily, it would be of particular assistance if the mother could occasionally attend the training sessions with the child so that she might learn from the example of the instructor how to handle the child during the rest of the week.

30. In some cases, it might be appropriate to arrange for children to attend a nearby hospital on a daily basis to receive suitable care and training. It might also be advantageous, in areas where separate accommodation could not be provided economically, for the local health authority and the education authority to combine in the provision of premises and facilities for junior occupation centres. In such centres common use might be made of equipment and dining and toilet accommodation, and of domestic staff and possibly of some training staff, but the training and occupation of the two categories of children would be undertaken separately.

31. Even when adequate provision of centres has been made, however, there will still remain a number of children for whom attendance at a day centre will be impossible, either because of the distances involved or because of the child's condition. We discuss in paragraphs 41 and 42 the difficult problem of residential occupation centres. At this stage we wish to mention only some possible solutions which do not involve the provision of special hostels by the local health authority.

32. We suggest first that local health authorities should make arrangements with the hospital service whereby mentally defective children for whom this is suitable may be admitted to hospital for a short period of intensive habit training and other treatment to make them as self-reliant as possible at home. This might of course be necessary even with children who, on return home, would be able to attend a day centre; but it would be of particular value in the case of those children who are not within reach of a centre at which they could receive any form of training. We should emphasise that the success of a scheme of this kind for frequent movement of patients between hospital and community must also depend on the adequacy of the local authority's supervisory services: parents will be the more willing to take their child back into the home after a period in hospital if they are assured of the continued advice and support of the local health authority and of the hospital.

33. Secondly, the statutory provisions do not of course limit local health authorities to providing occupation and training in groups or in special centres. In any areas of scattered population where it is not practicable even to form small groups for training purposes, we recommend that local health authorities should make individual arrangements for mentally defective children, with the threefold object of training the child in suitable home occupations, perhaps by peripatetic home teachers, of training the parent in the correct care of the child, perhaps through the health visitor/district nurse, and of relieving the parent of the constant task of looking after the child. Use might be made here of any suitable trained personnel married or retired in the neighbourhood.

34. Finally, in all areas it is essential that officers of the education authority should consult the local health authority officers who will become responsible

for the training and occupation of the child before the formal decision is taken that a child is unsuitable for education or training in a special school. In this way the education authority will be able to let the parent know of the arrangements which the local health authority propose to make for the child: the decision to report the child should appear not solely as an exclusion from the school system, but as far as possible as a more positive decision to transfer the child to training more suited to his needs.

Mental Defectives over 16

35. Local health authorities have a duty to provide training and occupation for all mental defectives over 16 who need it. This duty is not confined to those mental defectives whose handicap is so severe that their training and occupation were the responsibility of the local health authority during school age. At the same time, there are a number of bodies concerned with the training and employment of handicapped persons, including the mentally handicapped: the work of such agencies as the Youth Employment Service, the Ministry of Labour Disablement Resettlement Officer, and the advantages of registration under the Disabled Persons (Employment) Act, 1944, have already been fully discussed in relation to mentally handicapped persons in the Report on the Welfare Needs of Mentally Handicapped Persons*. We do not wish to suggest that local health authorities should trespass on the spheres of these other agencies: what we recommend is that local health authority officers responsible for the supervision of mental defectives should at all times keep in very close touch with the Youth Employment Service, the disablement resettlement services, employment exchanges, voluntary bodies and officers of the local authority's welfare department concerned with sheltered employment for disabled persons under the National Assistance Act. In this way they will be ready at all times to advise the mental defectives under their care of the best way in which to take full advantage of the services available to them.

36. In our view, however, the main task facing local health authorities is to provide occupation and training for those mental defectives who will never become capable of ordinary employment and whose defect is too severe to enable them to qualify for schemes of sheltered employment or the Ministry of Labour scheme for registration of disabled persons. These mental defectives will, by definition, remain the responsibility of a local health authority throughout life; and it is clear that the present provision of work centres and occupation centres for them is far from adequate. We recommend that wherever sufficient numbers of defectives can be brought together local health authorities should take immediate steps to set up senior occupation centres and work centres, where they have none at present, and to review and if necessary increase their present provision, where they have already established such centres.

37. We have spoken above of "work centres". We mean to imply by this centres in which the aim is not merely to occupy the patient, but also to provide him with something approaching the nature of work in the outside world, and so to give him a greater sense of self-reliance. In some centres of this type already established, the local authority obtain appropriate contract work from industry, and the money earned is distributed among the patients in supplement of their National Assistance allowance. We should emphasise, however, that it is not

* The Welfare Needs of Mentally Handicapped Persons, 1957. A Report by a Committee of the Scottish Advisory Council on the Welfare of Handicapped Persons. H.M.S.O. Price 1s. 3d. (by post 1s. 5d.).

enough merely to provide work; the mental defectives must also be equipped to deal with community life during non-working hours, and provision must therefore also be made for some social training.

38. Besides those mental defectives who will never become capable of ordinary or even sheltered employment, local health authorities may also find that there are in their area a number of mentally handicapped young persons who may eventually be capable of entering ordinary employment but who are not yet ready to do so at the time when they reach school leaving age. To assist these young people, local authorities should consider whether they could use their work centres to cultivate the discipline of industry, time-keeping, etc. We do not however wish to suggest that local health authorities should attempt anything in the way of training in particular skills for specific jobs in industry, unless there are particular circumstances in any area which make this desirable.

39. Although the numbers in need of a place in a local health authority senior occupation or work centre will be considerably larger than the numbers in need of junior occupation centre provision—since the duty of the local health authority is not, as in the case of school age children, confined to the very severely handicapped nor so limited in age—it may be desirable, as we suggest in paragraph 29, for local health authorities to combine to provide occupation or work centres, or for travelling instructors to teach in turn small groups brought together throughout an area. In areas where even small groups are not possible or appropriate, travelling instructors might be employed to train individual mental defectives in skills which might help to provide occupation, even if they do not provide the means of earning a living. (The same instructors might also work with the physically handicapped as part of the local authority's welfare services under the National Assistance Act.) Local health authorities might also arrange for farmers, crofters, etc., to train individual physically able mental defectives to be of some use in the countryside in which they reside. We would hope also that a number of local health authorities might examine the possibility of combining with each other to provide a rural training centre which would provide training in farming, market gardening and related skills for mental defectives who seemed likely to be able to find work in the community after a period at such a centre. This would probably also involve the provision of associated residential accommodation. Finally we would suggest again, as in the case of school age children, that in some areas there may be a place for arrangements with the hospital service whereby mental defectives could be admitted for a short period of intensive training with the object of enabling them to become more socially acceptable in the community on discharge.

RESIDENTIAL ACCOMMODATION

Short-term Homes

40. The problem of the extent to which local health authorities should be responsible for the provision of residential accommodation for mental defectives is one that has caused us considerable difficulty. We are however quite clear that all local authorities should make provision for short-stay residential accommodation for mental defectives, both adults and children, with the object of relieving those looking after them during periods of domestic stress or for holidays. In the cities and larger burghs, this provision might take the form of a specially provided home: in other areas the solution may be short-term admission to mental deficiency hospitals or to other local authority or voluntary

homes, provided always that the effect on other residents must be considered before a mental defective is introduced into a home not primarily intended for persons suffering from mental disorder. We recognise that it will not be economic for all local health authorities to provide special homes for this purpose, but we are clear that all local authorities should see that there is provision, not necessarily in their area, but available to people from their area, for the relief of defectives' families for short periods.

Longer term Hostels for School Age Children

41. We have also considered whether local health authorities should provide hostels in association with junior occupation centres. The children for whom such centres would cater are those whose defect is too severe to make them suitable for an education authority residential special school or occupation centre, who are not within reach of a local health authority day occupation centre, who cannot receive training and occupation at home, and who yet do not necessarily require treatment in hospital. It follows that the numbers in the area of any one local health authority for whom residential accommodation will be necessary will be very small and will range over all grades of handicap and all ages from 5 to 16. It can be argued therefore, that a small isolated local health authority hostel for these children could not compare favourably with a large mental deficiency hospital which could better provide for the different ages and grades of handicap and the necessary ancillary services.

42. On the other hand we also feel that if there are among these children any who are not in need of hospital care, it is wrong in general that they should be catered for by the hospital service. We therefore hope that local health authorities will, in drawing up their plans for the future development of their mental health services, consider the establishment of a residential junior occupation centre as a long-term objective. Such a hostel would cater, not only for those children in the community who are not within reach of a day centre, but also for any children in hospital who no longer need hospital care, perhaps those who have been stabilised by a period of intensive training such as we suggest in paragraph 32, but who in the normal course could not be discharged home because of the lack of a suitable day centre: we would not suggest however that local authorities should attempt to accommodate in hostels rather than hospital those children who appear likely to require constant and close supervision throughout life and who will never be able to take any significant part in the life of the community (see also paragraphs 46 and 47). Since the numbers involved would mean that any scheme for a residential junior occupation centre could only be established on a regional basis, any local health authority contemplating such a centre would have to co-operate with neighbouring local health authorities and also with the hospitals in the region, to ascertain the numbers of children who might be transferred from hospital care to the residential centre. An alternative possibility is that local health authorities might explore with the education authority for their area the possibility of establishing a hostel to provide both for children attending an education authority occupation centre and for children receiving training and occupation from the local health authority. We would stress here that the aim should be not strict adherence to formula, but the emotional and social welfare of the individual child.

43. We believe that there may also be a need for hostels for mentally handicapped children who are capable of education in day special schools but who,

because of unsuitable home environment or behaviour difficulties, are at present either taken into care by Children's Officers or admitted to mental deficiency hospitals. We recommend that local health authorities should consult with education authorities to see whether such a need exists in their own area, but we consider that the primary responsibility for meeting it rests with the education authority.

Residential Accommodation for Adults

44. We have considered various types of residential accommodation for adult mental defectives for which there may be a need in particular areas. Those in need of accommodation may be divided broadly according to their capacity for employment. In the first place mental defectives who can obtain outside employment may need special accommodation in a local authority hostel either because they are homeless, and cannot in the ordinary way find suitable lodgings; or, particularly in the case of school leavers and young adults and mental defectives leaving hospital, because they need, for a time, more supervision than they can receive at home or in lodgings. It is of course essential that hostels of this kind should be placed in or near centres of employment. Where the accommodation is intended partly for patients leaving hospital, it would be an advantage if the hospital authority and the local health authority co-operated to provide the service, in order to ensure continuity of care.

45. Secondly, we have already suggested that there may be a number of mental defectives who cannot obtain outside employment immediately on leaving school, or on discharge from hospital, but who could expect to become capable of ordinary employment after a period, perhaps a year or two, of further training in a work centre or training centre. There may be a case for the provision of residential accommodation at or near the centre for those in this group who are homeless, or whose homes are not within reach of the centre, or who require more supervision than they can receive at home. We have already suggested that residential farm training centres may be one answer to the problem of providing training and occupation in rural areas: there may also be a need for similar residential centres providing a training with a more industrial bias in cities and large burghs.

46. Next we come to the problem of those mental defectives who are incapable of ordinary employment, unsuitable for boarding-out with individual guardians and without homes in the community. Hostels for such defectives would have to be associated with centres to provide occupation during the day; they would also have to provide long-term accommodation since the residents would be likely to remain the responsibility of the local health authority throughout life. The problem of relieving the hospital service of the care of defectives of this type at present in hospital is a difficult one. Estimates of the numbers of mental defectives at present in hospital, who do not need hospital care and who could be discharged if alternative accommodation were available, vary widely according to differing views on the extent of the medical and nursing element in the care and training of mental defectives. The most we feel we can say at this stage is that local authorities should first concentrate on the provision of sufficient accommodation to meet the needs of mental defectives in the community, but should plan, in consultation with the hospitals serving their area, to relieve the hospital service in due course by providing more accommodation or by taking over some existing hospital accommodation for mental defectives who seem more suitable

for community than for hospital care. We would like to suggest here, however, that where such mental defectives require close and constant supervision and are incapable of taking any significant part in the life of the community, there would seem to be no advantage to them in a transfer to a local health authority hostel. Indeed such a transfer might be disadvantageous, since the relatively small numbers in the hostel would preclude a full range of activities and would also make it impossible to separate residents into groups according to personality, age or degree of handicap. We feel that the criterion should be whether they are in any real sense being returned to the community, or whether they are merely being transferred to what is in effect a small mental deficiency hospital provided by the local health authority.

47. There is also the problem of mental defectives of this type who are at present still in the community, and who may later need special accommodation, for example, because of the death or the old age of their parents. At the moment, there is little alternative to admission to an institution for such defectives. Some of them will require the same sort of supervision as we have referred to in paragraph 46. However, even in this category some will still have ties in the community and where these would be broken by admission to a mental deficiency hospital it would clearly be to the advantage of the mental defectives to be admitted to a local health authority hostel. Accordingly, we recommend that local health authorities should consider whether they can provide some long-term accommodation in their hostels as an alternative to admission to hospital for any mental defectives at present in the community who may later need special accommodation. Such hostels are desirable particularly for aged mental defectives: we consider it undesirable that mental defectives should be accommodated in the same homes as normal old people or mentally disturbed old people.

48. We hesitate to lay down any order of priority between the different groups which we have described as possibly in need of hostel accommodation. We recommend instead that every local health authority should consider the needs of their own area and make provision initially for whichever seems to be the most pressing. We should welcome here as many experiments as possible in different types of provision for different types of need. The same hostel might cater for several different types of need, subject to the following reservations. First, defectives with anti-social tendencies who might exercise a disturbing influence on other residents should not be accommodated in association with less difficult defectives. Secondly, we would not recommend the combination of a hostel for children with a hostel for adults, but we see no reason why the same hostel should not make provision for all ages of adult patients. Lastly, there may be some advantage in segregating the employable from those who are never going to be fit for ordinary or even sheltered employment, where numbers permit: but where numbers are small, the same hostel might accommodate both the employable and the unemployable.

OTHER SERVICES

Mental Defectives leaving Hospital

49. We have already referred to provision for mental defectives leaving hospital in our discussion of residential accommodation. We have also stressed the importance of adequate support from local health authority and hospital if parents are to be willing and able to receive back into the home mental defectives admitted to hospital for a short period of intensive training. The need for

adequate follow-up applies in the case of all mental defectives discharged from hospital. Local health authorities should ensure that they keep in close touch with the hospital: joint use by the hospital and the local health authority of welfare and other staff engaged in visiting the discharged patients would be an advantage. We should also mention that we consider that the education authority can contribute substantially by providing further education classes within the hospital, particularly for patients who are being prepared for discharge.

Maintenance Payments; Clothing and Bedding

50. As from the date of the repeal of section 26 of the Mental Deficiency and Lunacy (Scotland) Act, 1913, by section 1 of the 1960 Act, local health authorities will be relieved of the duty to make maintenance payments in respect of mental defectives under guardianship. Thereafter the National Assistance Board will be responsible for the making of maintenance payments where appropriate. It is important, in our view, that local health authorities responsible for the supervision of mental defectives should keep in close touch with the officers of the National Assistance Board dealing with maintenance payments in respect of the defectives. Mental defectives may have somewhat special needs on which the local health authority officer could give valuable advice. In some cases, for example, it might be desirable that part of the allowance should be provided in kind in the form of clothing, or alternatively that part of the weekly payment should be withheld and given to the guardian at intervals to purchase larger items of clothing. As the National Assistance Board will be taking over responsibility for maintenance payments, we would not expect local health authorities to continue themselves to issue clothing or bedding to adult mental defectives under their supervision. This might in some circumstances still be necessary, however, in the case of mentally defective children under 16, since we understand that the National Assistance Board are unable to pay an allowance in respect of a child unless the parents are themselves eligible for assistance.

"Sitter-in" Service

51. We have also considered the possibility that local health authorities should organise a "sitter-in" service designed to relieve parents of the care of home-bound mental defectives for short periods. We think that the need for such a service is probably limited: nevertheless local health authorities should consider whether there is a place for it in their own area. Such a service might appropriately be staffed by voluntary helpers, but we consider that the local health authority might assist in the organisation of it.

Social Clubs

52. We are of the opinion that there is a definite need for social clubs for mental defectives. A part-time club would be a useful first step where a local health authority could not immediately establish an occupation centre: such a club attached to an occupation centre would also be useful to keep in informal touch with those who have graduated from the centre to outside employment. Local health authorities might also encourage and support clubs for the parents of mental defectives under their supervision; as well as providing social activities, one of the important functions of such clubs would be to give practical help to the parents, in the form of talks or discussion groups with experts available for advice. We should emphasise, however, that social clubs are likely to be short-lived if they are run solely by the local authority: the interest and assistance of

those for whom the club is intended must be engaged and used. Local health authorities might also usefully co-operate with existing clubs run by hospitals.

Voluntary Help

53. It might be appropriate to end this section of our Report on services for mental defectives with the part which voluntary help can play. It is essential that local health authorities should keep in close touch with voluntary organisations in their area who are active in the sphere of mental health. In many cases these voluntary organisations have been responsible for setting up the first training and occupation centre in the area. Local health authorities are not necessarily required to provide training and occupation, residential accommodation, or other mental health services, at their own hand: but since it is their duty to see that satisfactory provision is made, we hope that they will give adequate financial and other support to any voluntary organisation providing services in the local authority's place in their area.

54. With regard to the use of untrained voluntary help in services provided by the local health authority themselves, in general we think that voluntary help can be of most assistance on the social and recreational side of the training and occupation of mental defectives; we would prefer the actual work of care and training to be done by those who are experienced and trained for it. There may also be scope for the use of voluntary assistance in the new field of hostel accommodation for mental defectives. Some local health authorities might also find that it would be useful to arrange short practical courses for suitable voluntary workers especially interested in the subject, but care would have to be exercised to make sure that the voluntary helpers were made fully aware of the type of work which would be involved.

SERVICES FOR THE MENTALLY ILL

Aftercare for those leaving Hospital

55. In the previous section we have been concerned with services for mental defectives, in whose case local authorities can expect that the majority of those for whom they cater will be capable of remaining within the community for all or most of their lives, that is, they will be mental defectives who have never been in hospital and who are unlikely to require admission to hospital provided local authority services are adequate. In contrast, in the case of the mentally ill, while local authorities can do valuable work in the sphere of prevention, with which we deal in paragraphs 60 and 61, a large part of their task will be to provide the aftercare services needed by patients leaving hospital; and we begin this part of our Report with this aspect of their services.

56. The annual number of discharges from mental hospitals in Scotland has been increasing in recent years from somewhat over 7,000 in 1955 to over 10,500 in 1959; and this does not include discharges from psychiatric units in general hospitals not designated as mental hospitals, which probably make a very significant addition to these figures. The new Act is not in itself likely to affect the total number of admissions or discharges, except that the provision for completely informal admission might be expected to reinforce the upward trend already existing. The number of patients leaving hospital each year may, therefore, continue to increase, at any rate for a further period. The majority of those discharged will have been in hospital for only a short time. It is not

possible to estimate how many of these patients may need or might benefit from some of the services which local health authorities have power to offer: this can only be assessed through practical experience and close co-operation between each local health authority and the hospital or hospitals catering for their area. A considerable proportion of patients admitted to hospital have been in a mental hospital on a previous occasion or occasions: a special survey by the General Board of Control has shown that 36% of all admissions during 1959 were re-admissions. While relapse and readmission are to be expected in certain types of mental illness, nevertheless effective medical and social care in the community should reduce the readmission rate. To that extent, aftercare is also a form of prevention.

57. Preparation for aftercare should begin even before a patient leaves hospital. (In what we say here we are concerned only with patients who need care in the community after discharge, and who have agreed to receive it: we mention again below the need to obtain the patient's consent.) The hospital doctor in charge of the patient, the patient's general practitioner, and the local health authority all have a part to play, and co-operation between them is essential. While the patient is in hospital, it is the hospital doctor's responsibility to keep in touch with the general practitioner, the general practitioner's part to ensure that the family at home are prepared for the patient's ultimate return, and the local authority's part to assist in the liaison between the patient and his family, if there is no hospital social worker available to do this. Where, perhaps because of the length of his stay in hospital, the patient is no longer on the list of a general practitioner, the hospital doctor should advise the patient's family to take the necessary steps to call in a general practitioner in good time for the patient's discharge. When the patient is discharged, it is the responsibility of the hospital doctor to advise the general practitioner on what aftercare is needed, and any further medical treatment needed by the patient will be given either by the general practitioner or at a hospital out-patient clinic. We do not consider it appropriate for the local authority to provide specialist psychiatric aftercare; their part is to provide, through suitably qualified social workers acting under the guidance of the hospital psychiatrist and/or general practitioner, any necessary support by means of home visits, and to provide continuity between the patient's period in hospital and his life in the community. The aim will be to ensure that adequate use is made of the medical and social services available in the community. We recommend that wherever possible the social worker who is to follow-up the patient in the community, whether officially employed by the local authority, by the hospital, or jointly by both, should make contact with the patient in the hospital to discuss arrangements for his future employment and any other problems arising from his discharge. We believe that there are many advantages in the joint use of psychiatric social workers by hospital and local authority, but where both the hospital and local authority employ separate social workers, the discharge of the patient from hospital should not mean an abrupt transfer of responsibility from one social worker to the other. In all cases the consent of the patient would be necessary before the local authority worker could be called in, but if this were put to them as a necessary and normal part of the arrangements for their full rehabilitation, the great majority of patients who are in need of aftercare would not refuse to co-operate.

58. It will be evident from what we have said above that the key to the problem of aftercare is integration between the hospital, general practitioner, and local

health authority services. It is essential that the hospital psychiatrist should supply the general practitioner with full and adequate information about his patient, and that both psychiatrist and general practitioner should see that the social worker possesses the information necessary to ensure an adequate follow-up of the case. Written communications are no substitute for personal contact, and we should welcome any arrangements whereby general practitioners and local authority social workers may participate with hospital doctors in case conferences. Finally, it is essential that local health authorities should see that general practitioners and hospital doctors are made aware of the aftercare services which they can make available, so that these can be fully used to the patient's advantage.

Patients under Guardianship

59. As we mentioned in paragraph 5, the new Act applies to mentally ill patients as well as to mental defectives the provisions for admission to formal guardianship under the supervision of local health authorities. At present it is very rare for mentally ill patients to be boarded-out in private dwellings (the equivalent of placing under guardianship) direct: most of those at present boarded-out are patients who have been in a mental hospital, have subsequently been discharged on probation, but who were not considered fit for full discharge after a year on probation, although they could remain in the community. Patients of this type are those for whom formal guardianship under the supervision of the local health authority might be appropriate once the new Act is in operation. The numbers are small, amounting to only 275 at the end of 1959, and we would not expect that the new legislation would lead to any great increase. As with mental defectives under guardianship, we recommend that supervision should take the form of regular, informal and friendly visits from local authority medical officers and social workers, who would obtain any specialist psychiatric guidance necessary from the hospital service.

Prevention of Mental Illness

60. Care from the local authority by means of home visits may be desirable in many cases to prevent the development of mental illness. We have in mind here particularly the elderly: regular visits from a local authority worker may be the means of keeping an old person living alone in good mental as well as physical health. To discuss all the services which local health authorities should provide for the elderly would be to go beyond our present remit, but we emphasise that the provision of a comprehensive service to keep old people active and alert is in our view one of the most important ways in which local health authorities can contribute towards the prevention of mental ill-health. Methods of keeping old people physically healthy, such as meals-on-wheels and chiropody services, are well known; but we would stress also methods of keeping them mentally alert, in particular, day centres and social clubs.

61. General practitioners may also know of other patients who have not been in a mental hospital and whose condition does not require specialist psychiatric treatment, but who need the reassurance of regular visits in order to prevent mental breakdown. Local health authorities should encourage general practitioners to ask for the support of local authority workers where they cannot themselves visit such patients with sufficient frequency. In other cases, where it would be difficult for the local authority to know how to handle the patient without psychiatric guidance, the general practitioner would no doubt first

refer the patient to a hospital out-patient clinic or to a hospital consultant by means of a domiciliary visit, so that both the general practitioner and the local authority might have specialist advice as to the kind of support needed. Again, we would welcome arrangements for general practitioners and local authority social workers to participate in case conferences.

Social Clubs

62. We recommend that local health authorities should initiate or encourage, if necessary by financial support, the formation of social clubs for mentally ill persons. Such clubs should be self-governing in day to day matters, although supervised by local authorities with psychiatric guidance. Local health authorities might also usefully co-operate with existing clubs run by hospitals.

Residential Accommodation

63. Setting aside for the moment the question of provision for the elderly, with which we deal separately in paragraph 67, we are of the opinion that the demand for hostels for mentally ill patients leaving hospital will not be very great, and will probably be confined to patients who have been in hospital for some considerable time and who will have to readjust themselves slowly to normal life in the community. Nevertheless we recommend that local health authorities should consider, in consultation with the hospitals serving their area, whether there is a need for such a hostel in their area. We should like to see local authorities and hospitals co-operating to provide this service. We have not attempted to lay down any general formula for determining the exact point at which the responsibility of the hospital for a discharged patient should end and that of the local health authority should begin; this will have to be settled individually in each case. Hostels in which both hospital patients and local authority patients are accommodated will ensure that the transfer of responsibility will not break the continuity of care.

64. We do not consider that it would be desirable to accommodate mentally ill patients in the same hostel as mentally defective patients.

65. We have considered whether there is a need for hostel accommodation for patients at present in hospital, who no longer require hospital care, but who are unemployable and have no home to go to. Any such hostel would have to be combined with an occupation or work centre to occupy the residents during the day; it would also have to provide for residents who would remain for a good many years. In general, we are of the opinion that local health authorities might consider whether there are in hospitals serving their area any such patients who are clearly not in need of full hospital services, and might take this into account, when drawing up their plans for the provision of hostels, as one of the needs which they should possibly meet. As in the case of the similar problem in respect of mental defectives (paragraphs 46 and 47), however, we would not think it appropriate for local authorities to attempt to provide for such of these patients who do not require medical or nursing care but who will always require constant and close supervision and will never be able to take any significant part in the life of the community; and we also suggest that local health authorities will probably wish to meet first the needs of those patients leaving hospital who can hope to enter with a fair measure of success into community life once more, before turning to this long-term problem.

Lodgings

66. We are of the opinion that local authorities could assist greatly by finding suitable lodgings for patients leaving mental hospitals, and by making themselves responsible for seeing that the lodgings reach a satisfactory standard. In many cases, such provision might prove of more value in the full rehabilitation of the patient than special hostel accommodation. Local health authorities should also consider whether voluntary organisations within their area might be able to give assistance in this respect. Consultation with officers of the National Assistance Board would be desirable before making final arrangements for lodgings in any case where the patient would be dependent on a National Assistance allowance to meet the cost.

Homes for Old People

67. We agree with the Dunlop Committee* in paragraph 37 of their Second Report that there is a need for homes for certain aged mentally disturbed patients. Such homes should be small, and situated near or in the area of the residents' own homes to avoid confusing them still further by removing them to large buildings and unfamiliar surroundings. Such homes can be provided either under National Assistance Act powers by the local authority as welfare authority or by the local health authority under section 27 of the National Health Service (Scotland) Act, 1947, and section 7 of the Mental Health (Scotland) Act, 1960. Whichever powers are used, we wish to emphasise the importance of full co-operation between the welfare department and the health department of the local authority.

Short-term Residential Accommodation

68. We have considered whether there is a need for short-term accommodation for mentally ill patients, in periods of domestic stress, or to give those looking after them a holiday. We think that admission to ordinary local authority homes would be undesirable, and that admission to hospital for a temporary period might be the best solution in many such cases. Where the local authority provide a hostel specifically for mentally ill patients, however, they should consider whether some of the places could be used to provide any short-stay accommodation of this kind which is needed. They might also consider making use of their knowledge of suitable lodgings (paragraph 66) to board out such patients for a short period.

69. In recent years the value of a holiday away from the hospital for long-stay hospital patients has been increasingly recognised. The provision of holiday homes for hospital patients is primarily the responsibility of the hospital authorities, but we hope that local health authorities will offer their assistance with such projects if the opportunity arises.

TRAINING AND OCCUPATION: EMPLOYMENT

70. The problem of training and occupation for mentally ill patients falls into two parts. There is first the rehabilitation and retraining of patients in hospital with the object of fitting them to take up employment in the outside world once more. Here, we consider that the diversity of the former occupations of patients makes it difficult for individual hospitals or individual local health authorities to

* Mental Health Legislation 1939, Second Report by a Committee appointed by the Scottish Health Services Council, H.M.S.O. Price 1s. (by post 1s. 2d.).

provide a full service of retraining because of the great range of jobs in which training would have to be given. We should therefore like to see an extension of Ministry of Labour Industrial Rehabilitation Units to cater more fully than the existing Units for mentally ill patients. So far as this need is not met by Industrial Rehabilitation Units, we consider that the rehabilitation of patients in hospital is the responsibility of the hospital service rather than of the local health authority. The local health authority can however assist by sharing with the hospital the responsibility for seeing that the patient finds a job on discharge. We have already mentioned, in paragraph 57, that we should like to see local authority social workers making contact with patients while still in hospital to consider, among other things, the problem of employment on discharge. The question of future employment should be considered well before the patient leaves hospital. We also mention in passing that we consider that the education authority can contribute substantially by providing further education classes within the hospital for patients who can benefit from this.

71. We do however consider that local health authorities have a part to play in the provision of occupation for patients whose mental illness has left them in effect with a permanent handicap, and who are unlikely to be able to enter ordinary employment again. Such patients who are no longer in need of full hospital care may be able to live at home provided that they can receive some form of daily occupation. There may be other such patients who have no home to go to, but who could be discharged from hospital if residential accommodation were provided in association with an occupation or work centre: we have already discussed this long-term problem in paragraph 65.

72. We do not necessarily suggest that local health authorities should provide separate workshops or centres devoted to mentally ill patients, although this may well be appropriate in large centres of population. Local health authorities who already run sheltered workshops under National Assistance Act powers mainly for physically handicapped persons may wish to place some mentally ill patients in these workshops. Some local authorities may also wish to combine a work centre for chronic deteriorated mental patients with a centre for mental defectives, although this is not always considered advisable. We should also very much like to see hospitals making available to local health authorities places in their workshops and occupation centres for patients attending daily from the community, and where necessary extending their accommodation to make room for these patients. The local health authorities would pay an appropriate share of the cost of the workshops and centres, which would continue to be staffed and administered by the hospitals. These arrangements would be particularly appropriate in rural areas. In our view, local health authorities should provide transport, or refund fares, for mentally ill patients attending work centres, and for elderly people attending the day centres we mention in paragraph 60, in the same way as they do for mental defectives — see paragraph 25.

CO-OPERATION

73. In various parts of this Report we have had occasion to mention the importance of co-operation between the various bodies providing services for

persons suffering from mental disorder. The health department of the local authority cannot work in isolation.

74. Co-operation with the education authority is essential at all stages up to and beyond school leaving age to ensure that mentally handicapped children receive the training best suited to their ability, and to ensure that all their needs are met: to ensure, for example, that home needs are not neglected while educational needs are satisfied (paragraphs 19 to 21).

75. The powers of the local authority under the National Health Service (Scotland) Act and under the National Assistance Act to some extent overlap, particularly in the sphere of training and employment (paragraphs 35 to 39) and in the provision of residential accommodation for old people (paragraph 67). To make the most effective use of these powers and to carry out their duties adequately it is essential that there should be close co-operation between the health and welfare departments of the local authority, where there is not already a combined health and welfare department. Co-operation with other bodies providing for the rehabilitation of the mentally ill and the training and employment of mentally handicapped people – the Youth Employment Service, the disablement resettlement service, employment exchanges, and Industrial Rehabilitation Units – and with the National Assistance Board is also essential (paragraphs 35, 50, and 70 to 72).

76. We have mentioned in many paragraphs of our Report the importance of enlisting the co-operation of general practitioners. We suggest that personal contact should be the aim, but where this is impossible, a personal letter from the Medical Officer of Health to all general practitioners in his area may be an effective way of securing co-operation. We emphasise again that unless general practitioners know that the local health authority are able to offer practical help, propaganda designed to encourage them to consult the local authority about cases of mental handicap, or to ask for the support of the local authority in the aftercare of the mentally ill, will be unsuccessful. We recommend that each local health authority should consider the best way of ensuring that general practitioners know of the services available in their area; one possible course would be to produce a pamphlet for issue to all concerned, but particularly to general practitioners.

77. We have assumed throughout our Report that local health authorities will also keep in close touch with mental deficiency and mental hospitals serving their area. This is particularly necessary in the sphere of training and occupation, both for mental defectives and for the mentally ill (paragraphs 33 and 70 to 72), in the provision of residential accommodation (paragraphs 40 to 48 and 63 to 69); and in the aftercare of patients leaving hospital (paragraphs 49 and 57 to 58). Where the problem of the confidentiality of medical records hinders the necessary exchange of information, the granting of an honorary hospital appointment to a local authority medical officer, or an honorary local authority appointment to a hospital officer, may provide a solution.

78. In other paragraphs of our Report we have mentioned co-operation with voluntary bodies interested in mental health and welfare. This is particularly necessary where a voluntary organisation provide training and occupation centres, residential homes, etc., which the local health authority would otherwise have to provide themselves (paragraph 52), but local authorities may also find that they can use voluntary help at many points in their own services: we have suggested only a few of the ways in which voluntary help might be of use.

79. The need for co-operation works both ways. Just as we hope that local health authorities will keep in close touch with other bodies providing services for persons suffering from mental disorder, we hope that these in turn will keep local health authorities informed of developments in their activities. We have been struck in our consideration of local health authority services by the interdependence of these and the services provided by other bodies: where provision is inadequate elsewhere, particularly where hospital accommodation and places in education authority special schools and occupation centres are insufficient, it is in turn impossible for local health authorities to fulfil their statutory duties. In no areas is the need for co-ordination more acute than in sparsely populated rural areas where only a combined effort can hope to provide an adequate service.

80. We conclude this section on co-operation by suggesting the establishment of joint committees representing at least local health authorities, hospitals, general practitioners and voluntary mental health associations, and possibly also welfare departments, the National Assistance Board and the Ministry of Labour, to keep under constant review the existing mental health services and plans for future development. Such committees would be no substitute for actual contact between officials and those professionally concerned, and we hope that in all cases a committee of officials would pave the way for the meetings of the full joint committee. We do not prescribe the precise area which such committees should cover. The area of one local health authority would in most cases probably be too small: the area of a Regional Hospital Board would in most cases probably be too large for the fairly detailed co-ordination which we have in mind. The method adopted in any one area must depend on the nature, size and number of the local authorities and other bodies concerned and the particular problems of the area.

GENERAL

81. In our view one of the main tasks before local authorities is to educate the public with the object both of promoting sound mental health principles and of enlisting public support for the care of the mentally disordered within the community. These are among the objects of the voluntary associations active in the sphere of mental health, with whom we have already advocated close co-operation. We recommend that, when considering the content of any health education which they provide, local health authorities should have regard particularly to the need to educate parents in the way to establish sound mental relationships within the family, and that they should also consider arranging themselves lectures, film shows and other forms of propaganda among the general public. Education authorities might also be encouraged to arrange further education classes in mental health.

82. We recognise that all that we recommend cannot be achieved immediately. We hope that all local authorities will recognise that they must devote an adequate proportion of their financial resources to this essential work; but the shortage of trained staff, which cannot be quickly remedied, is bound to prove a limiting factor at first. We have in a few places in this Report indicated ways in which local authorities may make a start if they cannot achieve a full service immediately. Generally, we recommend that local authorities, in drawing up their plans for the development of their mental health services, should be

guided in settling the order of priority by the contribution each item will make towards removing the need for admission or re-admission to hospital wherever possible and enabling the mentally disordered to play as full a part as possible in community life. This means that measures to enable the mentally handicapped and those recovering from mental illness to enter ordinary employment, or at least to contribute in some small way in occupation or work centres, and measures designed to give support and relief to those looking after mentally disordered persons in the home will receive priority over the more long-term task of providing for those who have no suitable home in the community and who at the moment may be in hospital for lack of alternative accommodation.

83. We have in various places in our Report suggested that there will be a need for local health authorities to co-operate to provide services. We hope that difficulties in reaching agreement over joint ventures will not delay the provision of services. We are divided in our view as to whether it is part of our function to suggest ways and means of avoiding such difficulties, but by a majority vote we wish to recommend, first, that every effort should be made to attain simplicity of administration, for example, that one authority should act as agent for the other rather than that a Joint Committee should be set up: and second, that the local authority associations should be asked to advise on any general principles to be applied to the allocation of financial responsibility, and on model financial schemes for joint services.

84. As a study group are at present considering the training of social workers in the light of the Younghusband Report, we have made no detailed recommendations on the qualifications or training of staff, but we are strongly of the view that local authorities should see that the officer in charge of their mental health services is suitably qualified.

85. Finally, we think it would be an advantage if this Committee could again review the state of local authority mental health services in two or three years' time, to assess what has in general been done, and to consider future development. We hope of course that local health authorities will themselves keep under constant review what they have achieved and what they can go on to do; and perhaps it would not be inappropriate to end by saying that we hope that each health committee of a local authority will appoint a mental health sub-committee, if they have not already done so, in order to ensure that mental health services receive the attention which they deserve.

86. We should like to acknowledge the valuable part played in the preparation of this Report by our Secretary, Miss P. A. Cox of the Department of Health for Scotland. Her knowledge of the subject and the skill with which she drafted our Report have been of great assistance to us.

I. M. ALLAN,

Chairman

(on behalf of the Committee).

February, 1961.